and hours incurred to perform the function for which the provider was certified. Both total compensation and total hours worked shall be reported for all employees.

(c) Payroll records shall be maintained by the provider to substantiate the staffing costs reported to the office. The records shall indicate each employee's classification, hours worked, rate of pay, and the department or functional area to which the employee was assigned and actually worked. If an employee performs duties in more than one (1) department or functional area, the payroll records shall indicate the time allocations to the various assignments.

(d) When an owner or related party work assignment is at or below a department head level, the hours and compensation shall be included in the staffing hours reported using the forms prescribed by the office. Such hours and compensation must be reported separately and so identified. Compensation paid to owners or related parties for performing such duties shall be allowed if the compensation paid to owner/related parties does not exceed the price paid in the open market to obtain such services by nonowners or nonrelated parties. Such compensation to owner/related parties is not subject to the limitation found in section 18 of this rule.

405 IAC 1-14.6-18 Allowable costs; calculation of allowable owner or related party compensation; wages; salaries; fees

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 18. (a) Compensation for owner, related party, management, general line personnel, and consultants who perform management functions, or any individual or entity rendering services above the department head level shall be subject to the annual limitations described in this section. All compensation received by the parties as described in this subsection shall be reported and separately identified on the financial report form even though such payment may exceed the limitations. This compensation is allowed to cover costs for all administrative, policymaking, decision making, and other management functions above the department head level. This includes wages, salaries, and fees for owner, administrator, assistant administrator, management, contractors, and consultants who actually perform management functions as well as any other individual or entity performing such tasks.

(b) The maximum amount of owner, related party, and management compensation for the parties identified in subsection (a) shall be the lesser of the amount under subsection (c), as updated by the office on July 1 of each year based on the average rate of change of the most recent twelve (12) quarters of the Gross National Product Implicit Price Deflator, or the amount of patient-related wages, salaries, or fees actually paid or withdrawn that were properly reported to the federal Internal Revenue Service as wages, salaries, fringe benefits, or fees. If liabilities are established, they shall be paid within seventy-five (75) days after the end of the accounting period or such costs shall be disallowed.

(c) The owner, related party, and management compensation limitation per operation effective July 1, 1995, shall be as follows:

Owner and Management Compensation

Beds	Allowance
10	$21,542
20	$28,741
30	$35,915
40	$43,081
50	$50,281
60	$54,590
70	$58,904
80	$63,211
90	$67,507
100	$71,818
110	$77,594
120	$83,330
130	$89,103
140	$94,822
150	$100,578

160 $106,311

170 $112,068

180 $117,807

190 $123,562

200 $129,298

200 and over $129,298+

$262/bed over 200

This subsection applies to each provider of a Medicaid-certified operation. The unused portions of the allowance for one (1) operation shall not be carried over to other operations.

05 IAC 1-14.6-19 Medical or nonmedical supplies and equipment

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 19. The approved per diem rate in nursing facilities includes the cost of both medical and nonmedical supply items, and the provider shall not bill the Medicaid program for such items in addition to the established rate. Under no circumstances shall medical or nonmedical supplies and equipment for nursing facility residents be billed through a pharmacy or other provider. Medical and nonmedical supply items for nursing facility residents that are reimbursed by other payer sources shall not be reimbursed by Medicaid.

405 IAC 1-14.6-20 Nursing facilities reimbursement for therapy services

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 20. (a) Therapy services provided to Medicaid recipients by nursing facilities are included in the established rate. Under no circumstances shall therapies for nursing facility residents be billed to Medicaid through any provider. Therapy services for nursing facility residents that are reimbursed by other payor sources shall not be reimbursed in the aggregate by Medicaid.

(b) For purposes of determining allowable direct care costs, the office or its contractor shall adjust the aggregate cost of therapy services reported on the Nursing Facility Financial Report to account for non-Medicaid payers, including Medicare, of therapy services provided to nursing facility residents. Such adjustments shall be applied in order to remove reported costs attributable in the aggregate to therapy services that may be reimbursed by other payers. The adjustment shall be updated quarterly and applied for rate setting purposes to all cost reports with rate effective dates beginning on or after the first day of the same calendar quarter.

405 IAC 1-14.6-21 Allocation of expenses

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 12-13-7-3; IC 12-15

Sec. 21. (a) Except as provided in subsection (b), the detailed basis for allocation of expenses between nursing facility services and other services in a facility shall remain a prerogative of the provider as long as the basis is reasonable and consistent between accounting periods.

(b) The following relationships shall be followed:

(1) Reported expenses and patient census information must be for the same reporting period.

(2) Nursing salary allocations must be on the basis of nursing hours worked and must be for the reporting period except when specific identification is used based on the actual salaries paid for the reporting period.

(3) Nothing in this rule is intended to alter the appropriate classification of costs on the annual financial report from the appropriate classification of costs under 405 IAC 1-14.1. No allocation of costs between annual financial report line items shall be permitted.

(4) Any changes in the allocation or classification of costs must be approved by the office prior to the changes being implemented. Proposed changes in allocation or classification methods must be submitted to the office for approval at least ninety (90) days prior to the provider's reporting year end.

405 IAC 1-14.6-22 Administrative reconsideration; appeal

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2

Affected: IC 4-21.5-3; IC 12-13-7-3; IC 12-15

Sec. 22. (a) The Medicaid rate-setting contractor shall notify each provider of the provider's rate after such rate has been computed. If the provider disagrees with the rate determination, the provider must request an administrative reconsideration by the Medicaid rate-setting contractor. Such reconsideration request shall be in writing and shall contain specific issues to be reconsidered and the rationale for the provider's position. The request shall be signed by the provider or the authorized representative of the provider and must be received by the contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor shall evaluate the data. After review, the Medicaid rate-setting contractor may amend the rate, amend the challenged procedure or determination, or affirm the original decision. The Medicaid rate-setting contractor shall thereafter notify the provider of its final decision in writing, within forty-five (45) days of the Medicaid rate-setting contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the rate-setting contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies as set out in subsection (d).

(b) If the provider disagrees with a rate redetermination result from a financial audit adjustment or

reportable condition affecting a rate, the provider must request an administrative reconsideration from the Medicaid financial audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the Medicaid audit contractor within forty-five (45) days after release of the rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the Medicaid audit contractor shall evaluate the data. After review, the Medicaid audit contractor may amend the audit adjustment or reportable condition or affirm the original adjustment. The Medicaid audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the Medicaid audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(c) If the provider disagrees with a rate redetermination resulting from a recalculation of its CMI due to an MDS audit affecting the established Medicaid rate, the provider must request an administrative reconsideration from the MDS audit contractor. Such reconsideration request shall be in writing and shall contain specific issues to be considered and the rationale for the provider's position. The request shall be signed by the provider or authorized representative of the provider and must be received by the MDS audit contractor within forty-five (45) days after release of the

rate computed by the Medicaid rate-setting contractor. Upon receipt of the request for reconsideration, the MDS audit contractor shall evaluate the data. After review, the MDS audit contractor may amend the audit adjustment or affirm the original adjustment. The MDS audit contractor shall thereafter notify the provider of its final decision in writing within forty-five (45) days of the MDS audit contractor's receipt of the request for reconsideration. In the event that a timely response is not made by the audit contractor to the provider's reconsideration request, the request shall be deemed denied and the provider may pursue its administrative remedies under subsection (d).

(d) After completion of the reconsideration procedure under subsection (a), (b), or (c), the provider may initiate an appeal under IC 4-21.5-3.

Rule 15. Nursing Facilities; Electronic Transmission of Minimum Data Set (MDS)

405 IAC 1-15-1 Scope

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 1. This section requires nursing facilities certified to provide nursing facility care to Medicaid recipients to electronically transmit minimum data set (MDS) information for all residents to the office of Medicaid policy and planning for use in establishing and maintaining a case mix reimbursement system for Medicaid payments to nursing facilities, and other Medicaid program management purposes.

405 IAC 1-15-2 Definitions

Authority: IC 12-8-6-5; IC 12-15-1-10; IC 12-15-21-2
Affected: IC 12-13-7-3; IC 12-15

Sec. 2. (a) The definitions in this section apply throughout this rule.

(b) "Case mix reimbursement" means a system of paying nursing facilities according to the mix of residents in each facility as measured by resident characteristics and service needs. Its function is to provide payment for resources needed to serve different types of residents.

(c) "Minimum data set" means a core set of screening and assessment elements, including common definitions and coding categories, that forms the foundation of the comprehensive assessment for all residents of long term care facilities certified to participate in the Medicaid program. The items in the MDS standardize communication about resident problems, strengths, and conditions within the facilities, between facilities, and between facilities and outside agencies. Version 2.0 (1/30/98) is the most current form to the minimum data set (MDS 2.0). The Indiana system will employ the MDS 2.0 or subsequent revisions as approved by the Health Care Financing Administration (HCFA).

(d) "Office" means the office of Medicaid policy and planning.